IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

Mary A. Froehlich	:	
	:	
Plaintiff,	:	Civil Action No. 05-CV-00564-SLR
	:	
v.	:	
	:	
Verizon, Inc., a Delaware corporation; Mutual of Omaha, a foreign insurance company	:	
	:	
Defendants.	:	
	:	

DEFENDANT VERIZON, INC.'S, ANSWER TO PLAINTIFF'S COMPLAINT

NOW COMES Verizon, Inc., ("Verizon") by and through counsel, and hereby responds to the Complaint as follows:

1. After reasonable investigation, Verizon is without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 1 and they are therefore deemed denied.

2. Admitted.

3. After reasonable investigation, Verizon is without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 3 and they are therefore deemed denied.

4. Denied as stated. Verizon did not exist at the purported date of hire of plaintiff's late husband. Defendant admits that he retired as an active employee of Verizon and/or its predecessor companies. After reasonable investigation, Verizon is without information or knowledge sufficient to form a belief as to Mr. Freohlich's marital status, but avers that it

presumes the allegation to be correct. It is further admitted that Mr. Froehlich retired and began receiving benefits from Verizon.

5. Admitted. By way of further response, the Long Term Care Plan constitutes a "Welfare Benefit Plan" within the meaning of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. Section 1001 et seq. Verizon Communications, Inc. is the Plan Sponsor and Administrator of the Plan within the meaning of ERISA. A copy of the Summary Plan Description for the Plan is attached hereto as Exhibit A.

6. After reasonable investigation, Verizon is without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 6 and they are therefore deemed denied.

7. Admitted. After reasonable investigation, Verizon is without knowledge or information sufficient to form a belief as to the range of dates during which premiums were paid via a pension deduction and they are therefore deemed denied.

8. After reasonable investigation, Verizon is without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 8 and they are therefore deemed denied.

9. After reasonable investigation, Verizon is without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 9 and they are therefore deemed denied.

10. Denied.

11. After reasonable investigation, Verizon is without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 11 and they are therefore deemed denied.

12. After reasonable investigation, Verizon is without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 12 and they are therefore deemed denied.

13. After reasonable investigation, Verizon is without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 13 and they are therefore deemed denied.

14. Denied.

WHEREFORE, Defendant seeks judgment in its favor, and against Plaintiff, together with attorneys' fees and costs as allowed by law.

COUNT I - SPECIFIC PERFORMANCE

15. Defendant Verizon incorporates by reference its responses to all preceding paragraphs of the complaint as if fully restated herein.

16. Denied.

17. After reasonable investigation, Verizon is without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 17 and they are therefore deemed denied. Additionally, the allegations of paragraph 17 are conclusions of law to which no responsive pleading is required, and they are therefore deemed denied.

18. After reasonable investigation, Verizon is without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 18 and they are therefore deemed denied. Additionally, the allegations of paragraph 18 are conclusions of law to which no responsive pleading is required, and they are therefore deemed denied

WHEREFORE, Defendant Verizon seeks judgment in its favor, and against Plaintiff, together with attorneys' fees and costs as allowed by law.

COUNT II - BREACH OF CONTRACT

19. Defendant Verizon incorporates by reference its responses to all preceding paragraphs of the complaint as if fully restated herein.

20. Denied.

WHEREFORE, Defendant seeks judgment in its favor, and against Plaintiff, together with attorneys' fees and costs as allowed by law.

COUNT III - NEGLIGENCE

21. Defendant Verizon incorporates by reference its responses to all preceding paragraphs of the complaint as if fully restated herein.

22. Denied.

WHEREFORE, Defendant seeks judgment in its favor, and against Plaintiff, together with attorneys' fees and costs as allowed by law.

COUNT IV - PROMISSORY ESTOPPEL

23. Defendant Verizon incorporates by reference its responses to all preceding paragraphs of the complaint as if fully restated herein.

24. The allegations of paragraph 24 are conclusions of law to which no responsive pleading is required, and they are therefore deemed denied.

WHEREFORE, Defendant seeks judgment in its favor, and against Plaintiff, together with attorneys' fees and costs and such other relief as allowed by law.

AFFIRMATIVE DEFENSES

1. Plaintiff's state law claims, in whole or in part, are preempted by the Employee Retirement Income Security Act.

2. Plaintiff's claims are barred by her failure to exhaust administrative remedies.

3. Plaintiff's claims are barred, in whole or in part, by the applicable statutes of limitations.

4. Plaintiff's claims are barred, in whole or in part, by the doctrine of equitable estoppel.

5. Plaintiff's claims are barred, in whole or in part, by the failure to timely remit premiums due under the Plan.

Respectfully Submitted,

THE NEUBERGER FIRM, P.A.

/s/ Stephen J. Neuberger
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Attorneys for Defendant Verizon, Inc.

Dated: August 15, 2005

Exhibit A

GROUP LONG TERM CARE BENEFITS

Verizon Communications
BASIC OPTION

Revised April 1, 1993

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision.

Forward your completed claim form to:

Mutual of Omaha Insurance Company
Group LTC Claims
Mutual of Omaha Plaza
Omaha, Nebraska 68175

CLAIM ASSISTANCE

If you need assistance with filing your claim or an explanation of how your claim was paid, contact the:

Mutual of Omaha Insurance Company
Group LTC Claims
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Phone: (800) 877-1052

IMPORTANT NOTICE

Please refer to the Master Policy which has been issued to the Policyholder for additional contractual provisions.

30-Day Right to Examine Certificate

Please read your Certificate-Booklet. If you are not satisfied, send it back to us within 30 days after you receive it. We will send back your money and this Certificate-Booklet will be considered to never have been issued.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Your certificate contains certain limitations and conditions on your eligibility for benefits. Please refer to the following sections of your certificate:

(a) The Schedule describes the amount of benefits you may receive when you receive covered services;

(b) The Exceptions section of the Long Term Care Benefits provision describes the limitations on your benefits;

(c) The Preexisting Conditions provision may affect your eligibility for benefits; and

The General Exclusions and Limitations contain additional limits and exclusions which may affect your eligibility for benefits.

The following applies if you were required to complete a health application

CAUTION! This coverage may not apply when you have a claim! Please read!

The issuance of this long-term care certificate is based on your responses to the questions on your application, a copy of which is attached. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your certificate. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at:

MUTUAL OF OMAHA INSURANCE COMPANY
S1-GROUP LONG-TERM CARE
MUTUAL OF OMAHA PLAZA
OMAHA NE 68175
1-800-877-1052

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CERTIFICATE OF INSURANCE

MUTUAL OF OMAHA INSURANCE COMPANY

Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

Mutual of Omaha Insurance Company certifies that Group Policy No(s). GMLC-2V65 (policy) has been issued to Verizon Communications (Policyholder).

You are insured as described in this Certificate-Booklet, subject to the terms and conditions of the policy. Your insurance begins on the date shown on your Certificate Validation Form.

Attach Your Certificate Validation Form Here.

Your insurance ends as set forth in the When Your Insurance Ends section of this Certificate-Booklet.

If the provisions of this Certificate-Booklet and those of the policy do not agree, the provisions of the policy will apply.

This Certificate-Booklet replaces any certificate previously issued under the policy.

DEFINITIONS

When used in the policy or your certificate:

Activities of Daily Living are:

(a) transferring (unable to get in or out of bed or move from bed to chair) and walking (unable to use a wheelchair or walk unassisted, even with braces, a walker, a cane or other aid);

(b) taking medication (ability to self-administer medication using proper dosage and devices without assistance of another person);

(c) eating (unable to consume food or other nourishment once it has been prepared and made available to the insured person);

(d) dressing (unable to put on and take off all necessary items of clothing and get clothing from drawers, closets, etc.);

(e) toileting (unable to get to and from the toilet, transfer on and off the toilet and associated personal hygiene); and

(f) bathing (ability to take a full body bath, shower or sponge bath without assistance including transferring to and from the tub or shower).

Activities of Daily Living Test is:

(a) for nursing care facility or hospice confinement, met when the insured person's physician and our medical staff confirms that the insured person is unable to perform three or more of the Activities of Daily Living without the assistance of another person; and

(b) for adult day care, home health care or home hospice care, met when the insured person's physician and our medical staff confirms that the insured person is unable to perform two or more of the Activities of Daily Living without the assistance of another person.

Adult Day Care Center means an organization:

(a) which provides a program of adult day care;

(b) is established and operated in accordance with state law;

(c) whose staff includes:
(1) a full-time director;

(2) one or more RNs in attendance at least four hours a day during operating hours;
(3) a registered dietitian;
(4) a licensed physical therapist; and
(5) a licensed speech therapist;

(d) which operates at least five days a week and operates a minimum of six hours and a maximum of 12 hours daily;

(e) which maintains a written record of medical services given to each client; and

(f) which has established procedures for obtaining appropriate aid in the event of a medical emergency.

Benefit Period is a period of time which:

(a) begins with the first day of nursing care facility or hospice confinement, home health care, adult day care or home hospice care; and

(b) ends when there is a continuous period of 180 days or more when the insured person is neither confined in a nursing care facility or hospice nor receiving home health care, adult day care or home hospice care.

Caregiver means a person who resides in the home and provides nonmedical services related to the Activities of Daily Living and companionship. This may be a family member.

Custodial Nursing Care means care which:

(a) is primarily for the purpose of assisting an insured person in performing the Activities of Daily Living; and

(b) could be rendered safely by a person without medical skills.

Expense means the expense incurred for a covered service or supply. A physician has to order or prescribe the service or supply. Expense is considered incurred on the date the service or supply is received. Expense **does not include** any charge:

(a) for a service or supply which is not medically necessary; or

(b) which is in excess of the usual and customary charge for a service or supply.

A **Functionally Necessary** service or supply means one which our medical staff and/or an Independent Medical Review believes is appropriate and consistent in accord with accepted standards of community practice.

The fact that the insured person's physician prescribes services or supplies does not automatically mean such services or supplies are functionally necessary and covered by the policy.

Home Health Agency means a public or private agency or organization licensed and operated in accord with state law to provide home health care.

Home Health Care Plan means a plan of continued care and treatment of an insured person:

(a) who is under the care of a physician; and

(b) who would need hospital or nursing care facility confinement without the home health care.

The Home Health Care Plan must be approved in writing by a physician.

Injury means an accidental bodily injury which requires treatment by a physician.

Insured Person means a person who is insured under the policy.

Mental and Nervous Disorders means any condition or disease, regardless of its cause, listed in the most recent edition of the **International Classification of Diseases** as a Mental Disorder. Not included in this definition are conditions or diseases specifically excluded from coverage.

Nursing Care Facility means a facility that:

(a) is licensed or certified by the state in which it is located to provide skilled, intermediate or custodial care as its main function;

(b) provides continuous room and board for at least three people;

(c) is supervised by an on-duty RN or LPN;

(d) maintains daily medical records; and

(e) maintains control and records for medication.

Nursing Care Facility shall not include a facility which primarily provides psychiatric treatment.

Our, We, Us means the Company shown on your Certificate of Insurance.

Physician means any of the following licensed practitioners acting within the scope of his or her license:

(a) a doctor of medicine (MD), osteopathy (DO), surgical chiropody, podiatry, or chiropractic;

(b) a licensed clinical psychologist; or

(c) where group insurance law requires, any other licensed practitioner who is acting within the scope of that license.

A physician does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister or parent of you or your spouse).

Respite Care means short-term care which is provided on a 24-hour basis in the insured person's home when the primary caregiver is absent. Respite care is provided as a means of giving temporary relief to a caregiver who regularly assists with home care and who resides in the insured person's home.

Rider means a provision added to the policy or your certificate to expand or limit benefits or coverage.

Skilled or Intermediate Nursing Care means care which:

(a) is performed under the direction of a licensed physician; and

(b) consists of nursing and rehabilitation services administered by registered nurses (RNs), licensed practical nurses (LPNs) or physical therapist.

Usual and Customary Charge means a charge for a service or supply which is no higher than the 90th percentile of our prevailing health care charges data. This data reflects a current statistical sampling of charges for services and supplies made in the same or comparable area.

For services or supplies for which data is unavailable, usual and customary will be determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area concerned.

Waiting Periods mean those days when an insured person is confined in a nursing care facility or hospice or receiving home health care, adult day care or home hospice care and the Activities of Daily Living Test is met. Benefits are not payable for these days. The Waiting Periods will be applied to each new Benefit Period. Days applied toward the Waiting

Period for confinement in a nursing care facility or hospice may be applied toward the Waiting Period for home health care, adult day care or home hospice care or days applied toward the Waiting Period for home health care, adult day care or home hospice care may be applied toward the Waiting Period for confinement in a nursing care facility or hospice, if within the same Benefit Period. The Waiting Periods are shown on your Certificate Validation Form.

GENERAL PROVISIONS

Eligible Employees

Active Employees

If you are a full-time employee of the Policyholder, you are eligible on the day you begin active employment with the Policyholder.

If you are a part-time employee under the age of 80 of the Policyholder, you are eligible on the day you begin active employment with the Policyholder.

You are eligible as long as:

(a) you are a regular employee of the Policyholder;

(b) you are and continue to be actively employed; and

(c) you receive compensation for your work from the Policyholder for your work for the Policyholder.

Active Employment and **Actively Employed** means working 25 hours or more a week for a regular full-time employee and less than 25 hours a week for a regular part-time employee at your:

(a) regular job; and

(b) customary place of employment or other location to which you must travel to perform your regular job.

Retired Employees

If you are a retired employee under the age of 80, you are eligible if you are receiving a service or disability pension from the Policyholder.

When Your Insurance Begins

Active Employees

You will become insured on the date shown on your Certificate Validation Form, provided you are actively at work on that day, if:

(a) you are an active full-time employee and we received your signed written request on, before or within 31 days from the day you become eligible; or

(b) you are an active part-time non-management employee hired before January 1, 1981 and we receive your signed written request during the initial enrollment period (February 15, 1990 through April 15, 1990).

If you are not actively at work on that day, your insurance will begin on the first day of the policy month which coincides with or follows the day you return to active work.

If you are an active part-time employee under the age of 80, you will become insured on the date shown on your Certificate Validation Form, provided you submit evidence acceptable to us that you are in good health.

If you are not actively at work on that day, your insurance will begin on the first day of the policy month which coincides with or follows the day you return to active work.

Exceptions

1. If, on the day your insurance is to begin:

   (a) you are on a regular paid day of vacation; or

   (b) such day is a regular non-working day;

   you will still be considered actively at work if you were available for work on the last preceding regular work day.

2. If, on the day your insurance is to begin, you do not report to work, you will be considered actively at work if you are available for work on that day.

3. If your customary place of employment is at your home, you will be considered actively at work if you are not confined on that day (as described in the Confinement Rule below).

NOTE: This insurance may not be reinstated once it has lapsed.

Retired Employees

If you are a retired employee, you will become insured on the date shown on your Certificate Validation Form, provided you submit evidence acceptable to us that you are in good health and you are not confined on that day (as described in the Confinement Rule provision).

We will determine the day your insurance begins.

Confinement Rule:

If you are:

(a) hospital confined;

(b) confined in any institution/facility other than a hospital; or

(c) confined at home and under the supervision of a physician;

insurance will begin on the first day of the policy month which coincides with or follows the day after such confinement ends.

If you are an active employee and you are:

(a) not confined; and

(b) not available for work;

insurance will begin on the first day of the policy month which coincides with or follows the day you return to active work.

NOTE: This insurance may not be reinstated once it has lapsed.

Late Request

If we receive your signed written request more than 31 days after becoming eligible, you must submit evidence of good health acceptable to us. We will determine the day insurance begins.

Amount of Coverage

Your amount of coverage is shown on the Certificate Validation Form and on the Schedule. Changes to coverage are subject to the provisions in the master policy.

Change In Your Classification

If you are an active employee, changes in your classification or coverage will take effect on the first day of the policy month which coincides with or follows the day of the change, provided you are actively at work on that day. If you are not actively at work, the change will not take effect until the first day of the policy month which coincides with or follows the day you return to your regular job.

If you are a retired employee, any changes in your classification will take effect on the first day of the policy month which coincides with or follows the day of the change, provided you are not confined on that day. If you are confined, the change will not take effect until the first day of the policy month which coincides with or follows the day the confinement ends.

NOTE: This insurance may not be reinstated once it has lapsed.

When Your Insurance Ends

Your insurance will end at midnight on the earliest of:

(a) the day the Policyholder withdraws coverage;

(b) the day any premium for your insurance is due and unpaid;

(c) the day before you enter the Armed Forces on active duty (except for temporary active duty of two weeks or less).

(d) the last day of the policy month in which you are no longer eligible under the policy; or

If you are eligible because of your employment, you will no longer be eligible when:

(a) you resign or are retired;

(b) you are no longer in an eligible class; or

(c) you do not satisfy:
(1) the requirements for hours worked; or
(2) any other eligibility condition in the policy.

However, in the event you retire and you are receiving a service or disability pension from the Policyholder, your insurance may be continued upon payment of the premium.

If your insurance ends for reasons other than retirement as shown in the above paragraph, you may continue your insurance in accord with the following provision:

Portability (Continuation of Insurance)

If your insurance ends in accordance with the above provisions (except for nonpayment of premium) you may continue coverage under the Policy.

This continuation is available without evidence of insurability provided you make a written request and send it along with the initial premium and billing fee, if any, to us at our Home Office within 31 days of insurance ending.

The following conditions apply to continued coverage:

(a) except as modified by these conditions (a) and (b), all other provisions of the Policy will continue to apply, including our right to terminate your insurance on the day any premium is due and unpaid; and

(b) we may, at our sole discretion, include or exclude the premium, claims and other financial experience of your certificate in any group experience rating calculation.

Grace Period

After the first premium has been paid, the insured person has a grace period of 31 days from each premium due date to pay the premium. Coverage will remain in force during the grace period; except, if advance written notice has been given to us that coverage will terminate prior to the end of the grace period, coverage will remain in force only until the termination date.

NOTE: A part-time or retired employee, spouse or parent can be eligible for the insurance provided under the policy only if such person is under age 80 on the date insurance would otherwise become effective.

SPOUSE ELIGIBILITY

(Long-Term Care Insurance)

Eligible Spouse

Only your lawful spouse is eligible for this Long-Term Care insurance.

Not Eligible

The following are not eligible for spouse insurance:

(a) your divorced spouse;

(b) a spouse who is eligible for long-term care insurance under the policy as an employee or member; or

(c) a spouse who is age 80 or older on the day insurance would become effective.

When Spouse Insurance Begins

If you want to insure your eligible spouse, evidence must be furnished that is acceptable to us that your spouse is in good health. If the evidence is acceptable to us, we will determine the date your spouse's insurance begins subject to the Confinement Rule below. We will furnish a Certificate Validation Form to your spouse.

Confinement Rule:

If a spouse is:

(a) hospital confined;

(b) confined in any institution/facility other than a hospital; or

(c) confined at home and under the supervision of a physician;

insurance will begin on the first day of the policy month which coincides with or follows the day after such confinement ends.

Change in the Amount of Insurance

Once you make an initial election of coverage for your spouse no subsequent changes may be made except as specifically provided for in the policy provisions.

When Insurance Ends

A spouse's insurance will end at midnight on the day any premium is due and unpaid.

This insurance may not be reinstated once it has lapsed.

When Affiliation Through the Policyholder Ends

A spouse's affiliation through the Policyholder will end at midnight on the earliest of:

(a) the day the Policyholder withdraws coverage;

(b) the day the spouse is no longer eligible; or

(c) the day your affiliation through the Policyholder ends.

When a spouse's affiliation through the Policyholder ends, insurance may be continued in accord with the following continuation provision.

Portability (Continuation of Insurance)

If affiliation through the Policyholder ends in accordance with the above provisions a spouse may continue coverage under the Policy.

This continuation is available without evidence of insurability provided a written request along with the initial premium and billing fee, if any, is sent to us at our Home Office within 31 days of insurance ending.

All provisions of the Policy will continue to apply, including our right to terminate insurance when the premium is due and unpaid, subject to any additional billing charges.

We may, at our sole discretion, include or exclude the premium, claims and other financial experience of your certificate in any group experience rating calculation.

Grace Period

After the first premium has been paid, the insured person has a grace period of 31 days from each premium due date to pay the premium. Coverage will remain in force during the grace period.

PARENTS ELIGIBILITY

(Long-Term Care Insurance)

Eligible Parents

Only the following are eligible for this Long-Term Care insurance:

(a) Your parents; and

(b) Your lawful spouse's parents.

Parents shall mean one male and one female person for you and one male and one female person for your spouse and shall include:

(a) a natural parent of you or your spouse;

(b) the person who legally adopted you or your spouse; or

(c) any other person who at one time was married to the natural or adoptive parent of you or your spouse.

You or your spouse may not change the designation of a parent once made. In addition, no more than two parents may be designated by the employee and no more than two may be made by the employee's spouse while insured under this policy.

Not Eligible

The following are not eligible for parents insurance:

(a) a parent who is eligible for long-term care insurance under the policy as an employee or member; or

(b) a parent who is age 80 or over on the day insurance would become effective.

When Parents Insurance Begins

If you want to insure a parent, evidence must be furnished that is acceptable to us that the parent is in good health. If the evidence is acceptable to us, we will determine the date insurance begins subject to the Confinement Rule below. We will furnish a Certificate Validation Form to each covered parent.

Confinement Rule:

If a parent is:

(a) hospital confined;

(b) confined in any institution/facility other than a hospital; or

(c) confined at home and under the supervision of a physician;

insurance will begin on the first day of the policy month which coincides with or follows the day after such confinement ends.

Change In the Amount of Insurance

Once a parent makes an initial election of coverage, no subsequent changes may be made except as specifically provided for in the policy provisions.

When Insurance Ends

A parent's insurance will end at midnight on the day any premium is due and unpaid.

This insurance may not be reinstated once it has lapsed.

When Affiliation Through the Policyholder Ends

A parent's affiliation through the Policyholder will end at midnight on the earliest of:

(a) the day the Policyholder withdraws coverage; or

(b) the day your affiliation through the Policyholder ends.

When a parent's affiliation through the Policyholder ends, insurance may be continued through the following continuation provision.

Portability (Continuation of Insurance)

If a parent's affiliation through the Policyholder ends in accordance with the above provisions the parent may continue coverage under the Policy.

This continuation is available without evidence of insurability provided a written request along with the initial premium and billing fee, if any, is sent to us at our Home Office within 31 days of insurance ending.

All provisions of the Policy will continue to apply, including our right to terminate insurance when the premium is due and unpaid, subject to any additional billing charges.

We may, at our sole discretion, include or exclude the premium, claims and other financial experience of your certificate in any group experience rating calculation.

Grace Period

After the first premium has been paid, the insured person has a grace period of 31 days from each premium due date to pay the premium. Coverage will remain in force during the grace period.

THE DEFINITIONS, GENERAL EXCLUSIONS AND LIMITATIONS AND RIDERS ARE VERY IMPORTANT PARTS OF THE POLICY. PLEASE READ THOSE PAGES CAREFULLY.

SCHEDULE

The amount of insurance for you, your spouse, and your parents will be in accord with the insured person's classification in this Schedule.

Classifications

All eligible employees

All eligible spouses

All eligible retirees

All eligible retiree spouses

All eligible parents

LONG-TERM CARE INSURANCE

For You, Your Spouse and Your Parents (All Classes)

NOTE: The Maximum Benefit is expressed as units of service. For your Maximum Benefit please refer to your Certificate Validation Form.

Maximum benefits payable for all Covered Services received on any one calendar day will not exceed the Maximum Daily Benefit.

Skilled or Intermediate Nursing Care Services

After the Waiting Period for confinement is met, we will pay 80% of the expense incurred but not to exceed the Maximum Daily Benefit shown on your Certificate Validation Form.

Each day shall be considered one unit of service.

Custodial Nursing Care Services

After the Waiting Period for confinement is met, we will pay 80% of the expense incurred but not to exceed 1/2 of the Maximum Daily Benefit shown on your Certificate Validation Form.

Each day shall be considered 1/2 unit of service.

Home Health Care and Respite Care Services

Home Health Care Services

After the Waiting Period for non-confinement is met, for each period we will pay 80% of the expense incurred but not to exceed 1/2 of the Maximum Daily Benefit shown on the Certificate Validation Form.

Each call shall be considered 1/2 unit of service.

Respite Care Services

After the Waiting Period for non-confinement is met, for each 12-hour period we will pay 80% of the expense incurred but not to exceed 1/2 of the Maximum Daily Benefit shown on the Certificate Validation Form, or in the aggregate 30 days in any 90-day consecutive period.

Each 12-hour period shall be considered 1/2 unit of service.

Adult Day Care Services

After the Waiting Period for non-confinement is met, we will pay 80% of the expense incurred but not to exceed 1/2 of the Maximum Daily Benefit shown on the Certificate Validation Form.

Each day shall be considered 1/2 unit of service.

Hospice Care Benefits

Home Hospice Care Services

For each call after the Waiting Period for non-confinement is met, we will pay 80% of the expense incurred but not to exceed 1/2 of the Maximum Daily Benefit shown on the Certificate Validation Form.

Each call shall be considered 1/2 unit of service.

Inpatient Hospice Care Services

After the Waiting Period for confinement is met, we will pay 80% of the expense incurred but not to exceed the Maximum Daily Benefit shown on the Certificate Validation Form.

Each day shall be considered one unit of service.

Froehlich-022

Benefits

If an insured person, while insured under this provision, incurs expense for Covered Services we will pay benefits as shown in the Schedule, provided the Activities of Daily Living Test is met. Benefits will be payable only for expense incurred after the Waiting Period. We will pay up to the Maximum Benefit for each insured person while insured under the policy. The **Waiting Period, Maximum Daily Benefit** and **Maximum Benefit** are shown on the **Certificate Validation Form.**

Covered Services

1. **Skilled or Intermediate Nursing Care Services**
   Skilled or Intermediate Nursing Care Services received while confined as a resident patient in a nursing care facility.
2. **Custodial Nursing Care Services**
   Custodial Nursing Care Services received while confined as a resident patient in a nursing care facility.
3. **Home Health Care and Respite Care Services**
   Home Health Care Services are the services and supplies listed below which are ordered and directed by a physician and are furnished:

   (a) in the insured person's home;

   (b) by a Home Health Agency; and

   (c) in accord with a Home Health Care Plan.

   1. Nursing Care provided on a part-time basis (less than an eight-hour shift) by:
      (a) a registered nurse (RN); or
      (b) a licensed practical nurse.
   2. Physical, occupational or speech therapy provided by a licensed therapist.
   3. Part-time or intermittent home health aide services provided:
      (a) by a home health aide; and
      (b) under the supervision of a registered nurse.

      Home Health Aide Services include (but are not limited to) helping the insured person with:

      (a) bathing and care of mouth, skin and hair;
      (b) bowel and bladder care;

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(c) getting in and out of bed and walking;
(d) exercises prescribed and taught by appropriate professionals;
(e) medication ordered by a physician;
(f) household services essential to the home health care (if the services would be performed if the insured person was in a hospital or skilled nursing facility); and
(g) reporting changes in the insured person's condition to the supervising nurse.

One home health care call will consist of:

(a) one visit for the services listed under Parts 3 (c)1 and 3 (c)2; or
(b) up to four consecutive hours for the home health aide services shown under Part 3 (c) 3.

4. Respite Care Services provided on a 24-hour basis and with the advance approval of our Long-Term Care ElderCare Specialist. (Call 1-800-877-1052.)

4. **Adult Day Care Services**
Adult Day Care Services received in an Adult Day Care Center.

5. **Home Hospice Care Services**
Home Hospice Care Services are the services and supplies listed below which are ordered and directed by a physician and are furnished:

(a) in the insured person's home;

(b) by a Home Health Agency or Hospice Agency; and

(c) in accord with a Hospice Care Plan.

1. Nursing care provided on a part-time basis (less than an eight-hour shift) by:
   (a) registered nurse (RN); or
   (b) licensed practical nurse.
2. Physical, occupational or speech therapy provided by a licensed therapist.
3. Part-time or intermittent home health aide services provided:
   (a) by a home health aide; and
   (b) under the supervision of a registered nurse.

Home Health Aide Services include (but are not limited to) helping the insured person with:

(a) bathing and care of mouth, skin and hair;

(b) bowel and bladder care;

(c) getting in and out of bed and walking;

(d) exercises prescribed and taught by appropriate professionals;

(e) medication ordered by a physician;

(f) household services essential to the home health care (if the services would be performed if the insured person was in a hospital or skilled nursing facility); and

(g) reporting changes in the insured person's condition to the supervising nurse.

One home hospice care call will consist of:

(a) one visit for the services listed under Parts 5 (c) 1 and 5 (c) 2; or

(b) up to four consecutive hours for the home health aide services shown under Part 5 (c) 3.

6. **Inpatient Hospice Care Services**

Inpatient Hospice Care benefits will be payable:

(a) when there are no suitable caregivers available to provide home hospice;

(b) when it is determined by the hospice agency that home hospice is impractical because the patient is unmanageable by the persons who regularly assist with home care; or

(c) for Hospice Respite Care.

Definitions (for Hospice Care Services)

Home Health Agency also means:

(a) a hospital;

(b) a visiting nurse association licensed by the state; or

(c) a nonprofit or public or private home health agency or organization licensed as such by the state.

Terminally Ill means:

(a) determined by a physician to have a terminal sickness with no reasonable prospect of cure; and

(b) expected by a physician to have less than six months to live.

Hospice Agency means a public or private agency or organization which:

(a) administers and provides hospice care; and

(b) is either:
  (1) licensed or certified as such by the state in which it is located;
  (2) certified (or is qualified and could be certified) to participate as such under Medicare;
  (3) accredited as such by the Joint Commission on the Accreditation of Hospitals; or
  (4) meets the standards established by the National Hospice Organization.

Hospice Care Plan means a coordinated, interdisciplinary program to meet the physical, psychological and social needs:

(a) of terminally ill persons and their families;

(b) by providing palliative (pain controlling) and supportive medical, nursing and other health services;

(c) through home or inpatient care during the sickness or bereavement.

Hospice Care Services means any services provided:

(a) under a hospice care program;

by a hospital or related institution, home health agency, hospice or other facility licensed by the state to operate the hospice.

Hospice Respite Care means short-term inpatient stays which may be necessary for the patient in order to give temporary relief to a caregiver who regularly assists with home care. Inpatient respite is limited each time to stays of no more than five days in a row.

Caregiver means a person not associated with the Hospice Agency who resides in the home and provides nonmedical services related to the Activities of Daily Living and companionship. This may be a family member.

Exceptions

We will not pay for:

(a) alcohol or drug abuse;

(b) nervous or mental disorders, except organic brain disorders as listed in the most recent edition of the International Classification of Diseases including Alzheimer's disease;

(c) for hospice care services, services and supplies which are not part of a Hospice Care Plan;

(d) services of a caregiver or a person who lives in your home or is a member of your family;

(e) domestic or housekeeping services that are unrelated to the patient's care;

(f) services which are not directly related to the insured person's condition, including (but not limited to):
  (1) estate planning, drafting of wills or other legal services;
  (2) pastoral counseling or funeral arrangements or services; or

(g) transportation services;

(h) expense incurred outside the United States, its territories or possessions;

(i) that portion of expense which is paid by any other provision of the Group Health Plan (whether insured or self-funded) provided by the Policyholder;

(j) any expense incurred after insurance ends (except termination of insurance will not affect a confinement which began prior to termination of insurance and which continues without interruption; subject to the Maximum Benefit and all other applicable policy provisions); or

(k) anything excluded under the General Exclusions and Limitations.

BENEFIT INCREASE PROVISION

While insured under this provision, each insured person may elect to increase the Maximum Daily Benefit amount by $20 on April 1, 1995, and every 5th anniversary of such date thereafter.

Conditions

1. The increase in coverage may not cause the Maximum Daily Benefit to exceed two times the initial Maximum Daily Benefit.
2. An insured person may not elect an increase in coverage if the benefit increase option date falls during a Benefit Period for that insured person.
3. A benefit increase may not be elected after the portability option under this policy has been selected.
4. Except for active full-time employees, a benefit increase may not be elected after the insured person reaches age 80. After the insured person reaches age 66, evidence of good health is required, except for active full-time employees. We will determine the effective date of the benefit increase.
5. Written request for the increase must be made on or within the 60 days prior to the date the increase would become effective.
6. If an insured person is an active employee of the Policyholder, the benefit increase will become effective on the premium due date coinciding with or next following the date the increase is elected, provided the insured person is actively at work. If the insured person is not actively at work, the benefit increase will begin on the first day of the policy month which coincides with or follows the day that he/she returns to active work.
7. If the insured person is not an active employee of the Policyholder, the benefit increase will become effective on the premium due date coinciding with or next following the increase, unless the insured person is over age 65, in which case evidence of good health is required as shown in 4 above, or unless the insured person is confined as described below.

Confinement Rule

If an insured person is:

(a) hospital confined;

(b) confined in any institution/facility other than a hospital; or

(c) confined at home and under the supervision of a physician;

the benefit increase will begin on the first day of the policy month which coincides with or follows the day after such confinement ends.

PREEXISTING CONDITIONS

If an insured person received treatment or service for an injury or sickness in the six-month period prior to that person becoming insured under the policy, we will not pay benefits for any loss or confinement which begins a Benefit Period:

(a) within six months from the time the insured person becomes covered under the policy; and

(b) is caused by that injury or sickness or any related conditions.

Benefits will not be payable for such preexisting condition(s) until the insured person has not incurred expense for such preexisting condition(s) for 180 days.

WAIVER OF PREMIUM

If an insured person incurs expense for Covered Services and such services are either applied to a Waiting Period or benefits have been paid for such services, and if the insured person incurs expense for such Covered Service in any 90 calendar days during any nine consecutive calendar months while this policy is in force, then insurance will continue without payment of premium which comes due for that insured person as long as the insured person remains in that Benefit Period. After the Benefit Period ends, premium will again become due on the next following premium due date for that insured person.

RETURN OF PREMIUM PROVISION

If an insured person, while insured under this provision:

(a) lapses coverage for any reason; or

(b) dies;

upon written request we will refund a percentage of the premium actually paid for the insured person based upon the following table, less the following amounts:

(a) any benefits paid;

(b) any benefits pending or due; and

(c) any dividends or experience rating credits paid or due.

RETURN OF PREMIUM TABLE

Full Number Of Years Coverage In Force For Insured Person	% of Premium To Be Refunded
0-1 Years	0%
1-5 Years	25%
6-10 Years	50%
11-15 Years	75%
16+ Years	100%

If the coverage for an insured person has been increased under the Benefit Increase Option, the above provision will be applied separately to each such increase selected and the applicable premiums and benefits.

If a claim is made under the policy after a return of premium has been made, any benefits payable will be reduced by the amount of premium that was returned for the insured person.

GENERAL EXCLUSIONS AND LIMITATIONS

We do not pay for:

(a) any injury or sickness for which the insured person is awarded or paid benefits under a worker's compensation or occupational disease law;

(b) any expense which is in excess of the usual and customary charges;

(c) any expense or charge for services or supplies not medically necessary or not recommended by a physician;

(d) any loss, expense or charge which results, whether the insured person is sane or insane, from:
(1) an intentionally self-inflicted injury or sickness; or
(2) suicide or attempted suicide;

(e) any loss, expense or charge resulting from the insured person's participation in a riot or in the commission of a felony;

(f) any expense or charge which the insured person does not have to pay;

(g) any expense or charge for services or supplies which are:
(1) not provided in accord with generally accepted professional medical standards;
(2) for experimental treatment; or
(3) investigative, and not proven safe and effective;

(h) any expense or charge for services or supplies which are provided or paid for by federal government or its agencies; except for:
(1) the Veterans Administration, when services are provided to a veteran for a disability which is not service-connected;
(2) a military hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services; or
(3) a group health plan established by a government for its own civilian employees and their dependents;

(i) any loss, expense or charge which results from an act of declared or undeclared war or armed aggression; or

(j) any loss, expense or charge:
   (1) which is incurred while the insured person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and
   (2) for which any governmental body or its agencies are liable.

COORDINATION OF BENEFITS (COB)

Definitions

Plan means any of the following coverages, including policy coverage and any coverage which is declared to be "excess" to all other coverages, which provide benefit payments or services to an insured person for hospital, medical, surgical, dental, prescription drug or vision care:

(a) Group or blanket insurance (except student accident insurance);

(b) Group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations);

(c) Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;

(d) Coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law;

(e) Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceeds $100 a day.

Claimant means the insured person for whom the claim is made.

Claim Period means part or all of a calendar year during which the claimant is insured under the policy.

A **Covered Expense** means any expense which is covered by at least one Plan during a Claim Period; however, any expense which is not payable by the Primary Plan because of the claimant's failure to comply with cost containment requirements (such as second surgical opinions, pre-admission testing, pre-admission review of hospital confinement, mandatory outpatient surgery, etc..) will not be considered a Covered Expense by the Secondary Plan. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Claim Period will also be considered a Covered Expense.

Coordination of Benefits (COB)

If the claimant is covered by another Plan or Plans, the benefits under the policy and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s).

1. The Primary Plan (which is the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.
2. The Secondary Plan (which is the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed the greater of:
   (a) 100% of total Covered Expense; or
   (b) the amount of benefits it would have paid had it been the Primary Plan.

The Order of Benefit Determination paragraph below explains the order in which Plans must pay.

This COB provision will not apply to a claim when the Covered Expense for a Claim Period is $50 or less; but if:

(a) additional expense is incurred during the Claim Period; and

(b) the total Covered Expense exceeds $50;

then this COB provision will apply to the total amount of the claim.

Order of Benefit Determination

When another Plan **does not** have a COB provision, that Plan must determine benefits first.

When another Plan **does** have a COB provision, the first of the following rules which applies govern:

(a) If a Plan covers the claimant as an employee, member or nondependent, then that Plan will pay its benefits first.

(b) If the above rule does not apply, the Plan which has covered the claimant for the longer period of time will pay its benefits first; except when:
   (1) one Plan covers the claimant as a laid-off or retired employee (or a dependent of such an employee); and

   (2) the other Plan includes this COB rule for laid-off or retired employees (or is issued in a state which requires this COB rule by law);

   then the Plan which covers the claimant as **other than** a laid-off or retired employee (or a dependent of such an employee) will pay first.

Where part of a Plan coordinates benefits and a part does not, each part will be treated like a separate Plan.

Credit Savings

Where the policy does not have to pay its full benefits because of COB, the savings will be credited to the claimant for the Claim Period. These savings would be applied to any unpaid Covered Expense during the Claim Period.

How COB Affects Policy Benefit Limits

If COB reduces the benefits payable under more than one policy provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those policy provisions.

Right To Collect and Release Needed Information

In order to receive benefits, the claimant must give the insurer any information which is needed to coordinate benefits. With the claimant's consent, the insurer may release to or collect from any person or organization any needed information about the claimant.

Facility of Payment

If benefits which this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are policy benefits and are treated like other policy benefits in satisfying policy liability.

Right of Recovery

If this Plan pays more for a Covered Expense than is required by this provision, the excess payment may be recovered from:

(c) the claimant;

(d) any person to whom the payment was made; or

(e) any insurance company, service plan or any other organization which should have made payment.

MEDICARE COORDINATION OF BENEFITS

Medicare COB

This Medicare COB provision applies when you:

(a) have health insurance under the policy; and

(b) are eligible for insurance under Medicare, Parts A and B, (whether or not you have applied or are enrolled in Medicare).

It applies before any other COB provision of the policy.

Effect on Benefits

1. If, in accord with the following rules, we have primary responsibility for your claims, then we pay policy benefits first.
2. If, in accord with the following rules, we have secondary responsibility for your claims:

   (a) first Medicare Benefits are determined or paid; and

   (b) then policy benefits are paid;

   but, for services payable under both plans, the combined Medicare Benefits and policy benefits will not exceed 100% of the expense incurred.

Rules for Determining Order of Benefits

1. **For You.** We have primary responsibility for your claims, if all of the following apply:

   (a) you are age 65 or older;

   (b) you are eligible for Medicare, Parts A and B, solely because of age; and

   (c) you are actively employed by an ADEA Employer which pays all or part of the policy premium.

   We have secondary responsibility for your claims when you are eligible for Medicare, Parts A and B, because of age, if you are not actively employed by an ADEA Employer which pays all or part of the policy premium.

2. **For a Disabled Person.** We have primary responsibility for your claims, if all of the following apply:

   (a) you are eligible for primary Medicare Benefits because you are disabled and have received Social Security disability benefits for 24 months in a row; and

   (b) your employer normally employed 100 or more employees on a typical business day during the previous calendar year.

   We have secondary responsibility for your claims if you are:

   (a) eligible for primary Medicare Benefits because you are disabled and have received Social Security disability benefits for 24 months in a row; and

   (b) your employer normally employed less than 100 employees on a typical business day during the previous calendar year;

   even if you are also eligible for Medicare, Parts A and B, because of age.

3. **For an Insured Person With End-Stage Renal Disease.** We have secondary responsibility for your claims if you are:

   (a) eligible for primary Medicare Benefits because of end-stage renal disease;

   (b) even if you are also eligible for Medicare, Parts A and B, because of age.

   We have primary responsibility for your claims when you are eligible for secondary Medicare Benefits solely because of end-stage renal disease.

Definitions

Medicare Benefits means benefits for services and supplies which the insured person receives or is eligible for under Medicare Part A or B, (whether or not the insured person has applied for or is enrolled in Medicare).

Age 65 (as used in this provision) means the age attained at 12:01 a.m. on the first day of the month in which the insured person's 65th birthday occurs.

ADEA Employer means an employer which:

(a) is subject to the U.S. Age Discrimination in Employment Act (ADEA); and

(b) has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding calendar year.

Important Information About Medicare

Medicare may affect policy benefits; therefore, you may want to contact your local Social Security office for information about Medicare. This should be done before your 65th birthday.

PAYMENT OF CLAIMS

How to File Claims

Before benefits are paid, we must be given a written proof of loss, as described below. In the event of your death or incapacity, your beneficiary or someone else may give us the proof.

Proof of Loss Requirements

1. First, request a claim form from us. Call: 1-800-877-1052

   This request should be made:

   (a) within 20 days after a loss occurs; or

   (b) as soon as reasonably possible.

   When we receive the request, we will send a claim form for filing proof of loss. If we do not send it within 15 days, you can meet the proof of loss requirement by giving us a written statement of what happened. We must receive a written statement within the time shown in 3 below.

2. Next, complete and sign the claim form. If a physician must complete part of the claim form, have the physician complete and sign that part.

3. Finally, return the claim form (with any bills) to the Plan Administrator or to us. The claim form is due:

   (a) within 90 days after the loss occurs; or

   (b) as soon as reasonably possible, but not later than one year after (a) above, unless the claimant is not legally capable.

When Claims are Paid

All policy benefits will be paid as soon as we receive acceptable proof of loss.

Direct Payments

Any benefits for hospital, medical, surgical, dental or vision services which you have assigned will be paid to the hospital or the provider of the services. If you have not assigned the benefits, we, at our option, will pay you or the hospital or the provider of the services.

Any other benefits will be paid to you except that benefits unpaid at your death may be paid, at our option, to:

(a) your beneficiary; or

(b) your estate.

If your beneficiary is unable to give a valid release or if benefits unpaid at your death are not more than $1,000, we may pay up to $1,000 to any relative of yours who we find is entitled to the benefit.

Any payment made in good faith will fully discharge us to the extent of the payment.

Examination and Autopsy

We sometimes require that a claimant be examined by a physician of our choice. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, we may also require an autopsy. We will pay for this autopsy.

STANDARD PROVISIONS

Insurance Contract

The insurance contract consists of:

(a) the policy;

(b) the Policyholder's application attached to the policy; and

(c) any application for you or any insured person.

Changes in the Insurance Contract

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time we and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

(a) does not require the consent of any insured person or beneficiary; and

(b) must be:
(1) in writing;
(2) made a part of the policy; and
(3) signed by one of our officers.

A change may affect any class of insured persons, including retirees if retired coverage is included in the policy.

Applications

We may use misstatements or omissions in the application of an insured person to contest the validity of insurance, reduce coverage or deny a claim; but we must first furnish you, your beneficiary or your personal representative with a copy of that application. We will not use a person's application to contest or reduce insurance which has been in force for two years or more during that person's lifetime. However, if you or your dependent is not eligible for insurance, there is no time limit on our right to contest insurance or deny a claim.

Statements in an application are treated as representations, not as warranties.

Legal Actions

No legal action can be brought until at least 60 days after we have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required.

SUMMARY PLAN DESCRIPTION

for
Verizon Communications

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an Employee Benefits Plan.

This certificate is your ERISA Summary Plan Description. Contributions are made solely by participants. Contributions are based on the amount of insurance premiums necessary to provide Plan coverage.

This Plan provides coverage for more than one class of employees.

PLAN IDENTIFICATION NUMBER

E.I.N.	P.N.
23-2259884	538

PLAN SPONSOR AND FORMAL PLAN ADMINISTRATOR

Verizon Communications
1310 North Court House Road
Arlington, Virginia 22201

AGENT FOR SERVICE OF LEGAL PROCESS

PLAN ADMINISTRATION

Verizon Communications
1310 North Court House Road
Ninth Floor
Arlington, Virginia 22201

CLAIM ADMINISTRATION

Group Long-Term Care Claims
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Phone (800) 877-1052

PLAN YEAR

Each 12-month period beginning on January 1 is a Plan Year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

STATEMENT OF ERISA RIGHTS

As a participant in this Group Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

(a) examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including insurance contracts, a list of participating employers sponsoring the Plan and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions. Upon written request you may receive information as to whether a particular employer or employee organization is a sponsor of the Plan and, if so, the sponsor's address.

(b) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

(c) receive a summary of the Plan's annual financial report, if there are 100 or more participants in this Plan. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefits Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs or fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIM REVIEW PROCEDURES

If your claim is denied or partly denied, you will receive written notice of the denial, together with the specific reason for the denial, directly from us. You may appeal any denial directly to us within 60 days after receiving the denial notice. We will inform you within 60 days after we receive your written appeal, unless an unusual circumstance requires an extension of time to investigate or consider your appeal. If this occurs, we will inform you of the reason and the additional time needed, not to exceed an additional 60 days.

We will make a claim decision within 90 days following our receipt of your written claim for benefits, unless an unusual circumstance requires an extension of time to investigate or consider your claim. If this occurs, we will inform you of the reason and the additional time needed, not to exceed an additional 90 days.

AUTHORITY TO INTERPRET POLICY

By purchasing this Policy, the policyholder grants us the discretion and the final authority to construe and interpret the Policy. This means that we have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by us. In making any decision, we may rely on the accuracy and completeness of any information furnished by the Policyholder or an insured person. Our interpretation of the Policy as to the amount of benefits and eligibility shall be binding and conclusive on all persons.

The Policyholder, as plan sponsor, agrees that the Policyholder retains full responsibility for the legal and tax status of its benefits program and releases us from all responsibility for the reporting and the employment-based design of the program and from all other responsibilities not accepted in writing by an officer of ours.

ATTACH APPLICATION HERE
(WHEN REQUIRED)

MEDICARE COORDINATION OF BENEFITS RIDER

Medicare COB

This rider is made a part of Group Policy GMLC-2V65.

This rider is effective the later of: (a) the effective date of your policy; or (b) the date required by Federal Law.

If the provisions of this rider and those of the policy or your certificate do not agree, the provisions of this rider will apply.

This Medicare COB provision applies when you:

(a) have health insurance under the policy; and

(b) are eligible for insurance under Medicare, Parts A and B, (whether or not you have applied or are enrolled in Medicare).

It applies before any other COB provision of the policy.

Effect on Benefits

1. If, in accord with the following rules, we have primary responsibility for your claims, then we pay policy benefits first.
2. If, in accord with the following rules, we have secondary responsibility for your claims:

   (a) first Medicare Benefits are determined or paid; and

   (b) then policy benefits are paid;

   but, for services payable under both plans, the combined Medicare Benefits and policy benefits will not exceed 100% of the expense incurred.

Rules for Determining Order of Benefits

1. **For You.** We have primary responsibility for your claims if:

   (a) you are insured under the policy because of your current active employment status with an ADEA employer, and you are eligible for Medicare benefits because of age; or

   (b) the policy is part of a large group plan, and you are insured under the policy because of your current active employment status, and you are eligible for Medicare benefits because of disability.

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We have secondary responsibility for your claims if you are eligible for Medicare benefits and the above conditions do not apply.

2. **Exception for End Stage Renal Disease.** If Medicare does not already have primary responsibility when you become eligible for Medicare benefits because of end stage renal disease:

   (a) we have primary responsibility for your claims for up to 18 months beginning with the month in which you are first eligible for Medicare benefits because of end stage renal disease; and

   (b) we have secondary responsibility after the end of this 18-month period.

Definitions

Medicare benefits means service and supplies which you receive or are eligible for under Medicare Part A or B, (whether or not the insured person has applied for or is enrolled in Medicare).

ADEA employer means an employer which:

(a) is subject to the federal Age Discrimination in Employment Act (ADEA); and

(b) has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding calendar year.

Large group plan means a plan which covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

Important Information About Medicare

Medicare may affect policy benefits; therefore, you may want to contact your local Social Security office for information about Medicare. This should be done before your 65th birthday.

MUTUAL OF OMAHA INSURANCE COMPANY

John A. Sturgeon

President

NOTICE

This notice is to advise you that should any questions or problems arise regarding this insurance, you may contact the Company at:

Mutual of Omaha Insurance Company
Attention: Washington, D.C. Group Office
1401 New York Avenue, N.W., Suite 1230
Washington, DC 20005
Telephone: 1-(202) 662-1440

If you have been unable to contact or obtain satisfaction from the Company, you may contact the Virginia Bureau of Insurance at:

Virginia Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218
Telephone 1-(800) 552-7945 (in-state only)
1-(804) 371-9741 (out-of-state)

Written correspondence is preferable so a record of your inquiry is maintained. When contacting the Company or Bureau of Insurance, have your policy number available.

This notice is for information only and does not become a part or condition of the policy.

Froehlich-052

CLAIM REVIEW AND APPEAL PROCEDURES

(as Federally Mandated)

For Group Policy GMLC-2V65, this provision is effective the later of:

(a) the effective date of the Policy; or

(b) the date required by Federal law.

Definitions

Capitalized terms have the same meaning as shown in the Policy.

For the purposes of this provision:

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment, (in whole or in part), for a benefit, including, without limitation, any such denial, reduction, termination of, or failure to provide or make payment that is based upon:

(a) the Insured Person's ineligibility for insurance under the Policy; or

(b) Our determination that the treatment or service is not a Covered Service under the Policy.

Day(s) means calendar day(s).

For the purposes of these Claim Review Procedures, the terms **You, Your, Yours** shall include Your authorized representative.

Claim Review Procedures

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below.

In the event an extension is necessary due to matters beyond Our control, We will notify You of the extension and the circumstances requiring the extension. Except where You voluntarily agree to provide Us with additional time, extensions are limited as set forth below.

If an extension is necessary due to Your failure to submit complete information, We will notify You of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

Froehlich-053

In order for Us to continue processing Your claim, the missing information must be provided to Us within the time periods set forth below.

You may contact Us at any time for additional details about the processing of the claim.

Claims or Requests

(a) Initial review: 30 days unless additional information is requested as set forth below;

(b) Extension Period: 15 days; and

(c) Maximum number of extensions: one.

If additional information is needed, We will notify You within five days of Our receipt of the request. Once You receive Our request for additional information, You will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

Claim Denials

If a request for a claim is denied or partly denied, You will receive a written or electronic notice of the denial, which will include:

(a) the specific reason(s) for the denial;

(b) reference to the specific Policy provisions on which the denial is based;

(c) if applicable, a description of any additional material or information necessary to complete the claim and the reason We need the material or information;

(d) a description of the appeal procedures; the applicable time frames, including Your right to request an appeal within 180 days and Your right to bring a civil action following the appeal process; and

(e) any other information which may be required under state or federal laws and regulations.

Additionally, if We made an Adverse Benefit Determination, You will receive a statement of Your right to receive, upon request and free of charge, any internal rule, guideline, protocol or other similar criterion We used in making an Adverse Benefit Determination.

Furthermore, if We make an Adverse Benefit Determination We will include a statement that an explanation of the scientific or clinical judgment for such determination will be provided to You upon request, free of charge.

Opportunity To Request An Appeal

You shall have a reasonable opportunity to appeal Our claim review decisions in accordance with this Claim Review and Appeal Procedures provision. As part of the appeal, there will be a full and fair review of the claim review decisions.

The request for an appeal can be written, electronically or orally submitted and should include any additional information You believe may have been omitted from Our review or that should be considered by Us.

We will establish and maintain procedures for hearing, researching, recording and resolving any appeal. The notification You receive regarding Our claim review decision will include instructions on how and where to submit an appeal.

You will have no later than 180 days from Your receipt of notification of Our claim review decision to submit a request for an appeal.

The request for an appeal should include:

(a) the name of the patient;

(b) the name of the person filing the appeal if different from the patient;

(c) the policy number;

(d) the member number;

(e) the nature of the appeal; and

(f) names of all individuals, facilities and/or services involved with the appeal.

By requesting an appeal, You have authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, Your medical records) which We determine may be relevant to Your appeal.

Our Response To Appeals

Once We receive Your request for an appeal, We will respond no later than 60 days for claims and services.

When We make Our determination You will be provided with:

(a) information regarding Our decision; and

(b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

This provision explains Your appeal rights under the Policy.

SUMMARY PLAN DESCRIPTION

For Group Policy GMLC-2V65 this Notice is effective the later of:

(a) the effective date of the Policy; or

(b) the date required by federal law.

Your Summary Plan Description is revised to include the following:

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The Employee benefits plan maintained by the Policyholder shall be referred to herein as the "Plan."

This Certificate is Your ERISA Summary Plan Description for the health insurance benefits described herein.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

(a) Receive Information About Your Plan and Benefits
  (1) Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) **filed** by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
  (2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
  (3) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

(b) Continue Group Health Plan Coverage
  (1) Continue health care coverage for Yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your dependents may have to pay for such coverage. Review this Summary Plan

Description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

(2) Reduction or elimination of exclusionary periods of coverage for preexisting conditions under Your group health plan, if You have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from Your group health plan or Us when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage. Without evidence of creditable coverage, You may be subject to a preexisting condition exclusion period after Your enrollment date in Your coverage.

(c) Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a benefit or exercising Your rights under ERISA.

(d) Enforce Your Rights

If Your claim for a benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support

order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

(e) Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

PLAN DISCLOSURES

You or Your dependent are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, Your Certificate includes, as applicable, a description of:

(a) Qualified Medical Child Support Orders;

(b) any cost-sharing provisions, including premiums, deductibles, coinsurance and copayments, maximums, details about the level of benefits, providers, out-of-network coverage, and/or limits on emergency care;

(c) employee and dependent eligibility requirements;

(d) any participating provider requirements; a current listing of such providers shall be furnished automatically as a separate document;

(e) when insurance ends;

(f) when benefits may be denied or reduced, including Coordination of Benefits provisions;

(g) state or federal continuation rights; and

(h) claims procedures; additional details shall be furnished upon request.

AUTHORITY TO INTERPRET POLICY

By purchasing the Policy, the Policyholder grants Us the discretion and the final authority to construe and interpret the Policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by Us. Benefits under the Policy will be paid only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder or an Insured Person. Our interpretation of the Policy as to the amount of benefits and eligibility shall be binding and conclusive on all persons.

The Policyholder, as Plan sponsor, agrees that the Policyholder retains full responsibility for the legal and tax status of its benefits program and releases Us from all responsibility for the reporting and the employment-based design of the program and from all other responsibilities not accepted in writing by an officer of Ours.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan or the Policy on behalf of the Policyholder are the Policyholder's Board of Directors or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action. Please refer to the provision in Your Certificate entitled "Changes in the Insurance Contract" for additional information about how the Policy can be changed. The Policyholder is authorized to apply for and accept the Policy and any changes to the Policy on behalf of the Policyholder.

Group Policy Number GMLC-2V65

CERTIFICATE OF SERVICE

I, Stephen J. Neuberger, being a member of the bar of this Court, do hereby certify that on August 15, 2005, I caused a two (2) copies of **Defendant Verizon Inc.'s Answer to Plaintiff's Complaint**, to be served by U.S. Mail on the following individuals:

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Attorneys for Defendant Mutual of Omaha

/s/ Stephen J. Neuberger
STEPHEN J. NEUBERGER, ESQ.

Dated: August 15, 2005